John Elias Baldacci
Governor

John R. Nicholas
Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011
Bureau of Medical Services

TO: Interested Parties

FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services

DATE: August 27, 2004

SUBJECT: Adopted Rule: Chapters II and III, Section 26, Day Health Services

In order to manage expenditures going forward, and to establish eligibility and service limits consistent with how other home and community based services are structured, this rule limits the number of hours of Day Health Services covered under Section 26 to 16 per week, except for certain members. Members who meet new requirements set forth in the rule may receive up to 24 hours of services per week under "Level II" in Section 26. Those members meeting nursing facility level of care eligibility requirements, as set forth in Section 67.02, may receive up to 40 hours per week of covered services under "Level III" in Section 26.

There is also language requiring the use of the Department's MED assessment form to determine level of eligibility for members receiving services under Section 26. Furthermore, the rule dictates that in order for the reimbursement of services to continue uninterrupted beyond a member's approved classification period, a reassessment and prior authorization of services is required.

Additionally, the Department eliminates procedure codes S5101 and S5102 in Chapter III, Section 26. They are replaced with two new codes in Chapter III that, along with existing code S5100, correspond to the levels of care and hourly limits imposed in the rule.

Rules and related documents may be reviewed and printed from the Bureau of Medical Services website at www.maine.gov/bms/MaineCareBenefitManualRules.htm or, for a fee, interested parties may request a paper copy of rules by calling Lucille Weeks at 207-287-9368.

Notice of Agency Rule-Making Adoption

Agency: Department of Health and Human Services, Bureau of Medical Services

Chapter Number And Title: Final rule, MaineCare Benefits Manual, Chapters II and III, Section 26, Day Health Services

Adopted rule number: (assigned by secretary of state)

CONCISE SUMMARY: In order to manage expenditures going forward, and to establish eligibility and service limits consistent with how other home and community based services are structured, this rule limits the number of hours of Day Health Services covered under Section 26 to 16 per week, except for certain members. Members who meet new requirements set forth in the rule may receive up to 24 hours of services per week under "Level II" in Section 26. Those members meeting nursing facility level of care eligibility requirements, as set forth in Section 67.02, may receive up to 40 hours per week of covered services under "Level III" in Section 26.

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Effective date: September 1, 2004

Agency Contact Person: Julie Tosswill

Agency name: Bureau of Medical Services
Division of Policy and Provider Services
11 State House Station
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Please approve bottom portion of this form and assign appropriate MFASIS number

APPROVED FOR PAYMENT _____ **DATE:** _____

Authorized Signature

FUND: 013 **AGENCY:** 10A **ORG:** 3010 **APP:** 012 **JOB:** **OBJT:** **AMOUNT:**

SECTION 26 **DAY HEALTH SERVICES** 6/15/90

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SECTION 26 **DAY HEALTH SERVICES** 6/15/90

26.01 DEFINITIONS

26.01-1 **Day Health Services** are health services that are needed to insure the optimal functioning of the member that are provided through a day health service. These services must be provided under an individual plan of care and outside the member's residence.

26.01-2 **Day Health Program** is a service that provides day health services and is licensed by the Department of Health and Human Services, Bureau of Elder and Adult Services.

Eff. 9-1-04

26.01-3 **Nursing Services** are services provided by a registered nurse and/or a licensed practical nurse within appropriate professional licensing regulations. They include, but are not necessarily limited to, monitoring health problems, monitoring and administering medication, and performing skilled tasks.

26.01-4 **Cuing** is any spoken instruction or physical guidance which serves as a signal to do something. Cuing is typically used when caring for individuals who are cognitively impaired.

26.01-5 **Limited Assistance** describes an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means that although the individual was highly involved in the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:

- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times, or

- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times plus weight-bearing support provided only one or two times.

26.01-6 **One-person Physical Assist** requires one person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last 7 days, or 24 to 48 hours if in a hospital setting. This does not include cuing.

26.01.7 **Extensive Assistance** means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours in a hospital setting, help of the following type(s) was provided:

Eff. 9-1-04

- Weight-bearing support three or more times, or

- Full staff performance during part (but not all) of the last 7 days.

26.01-8 **Medical Eligibility Determination (MED) Form** is the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions,

26.01 **DEFINITIONS** (cont.)

scoring mechanisms and time-frames relating to this form are outlined in the MED form and provide the basis for services and the care plan. The care plan summary contained in the MED form documents the authorized service plan. The care plan summary also identifies other services the member is receiving, in addition to the authorized services provided under this Section.

26.02 **ELIGIBILITY FOR CARE**

26.02-1 **General Requirements**

A member is eligible to receive services as set forth in this Section if he or she meets the general MaineCare eligibility requirements and the specific MaineCare eligibility requirements. Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

Eff. 9-1-04 26.02-2 **Specific Day Health Services Eligibility Requirements**

The member must be assessed by the day health services provider or other Department's authorized assessing agent, using the Department's approved medical eligibility assessment form. A member must require assistance with a combination of activities of daily living and nursing at specific levels in order to meet eligibility for specific levels of care. A member is medically eligible for day health services under this section if he or she meets the criteria set forth in (A), (B) or (C) below:

A. Level I: A member meets the eligibility requirements for Level I if the following are met:

1. Member requires daily (7 days per week) "Cuing" (defined in Section 26.01) for all items: 26.02-2 (A) (2), (d), (e), (f) and (g) listed below;

OR

2. At least "limited assistance" (defined in 26.01) and a "one-person physical assist" (defined in 26.01) are needed with at least two of the following activities of daily living:

a. Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

b. Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

26.02 **ELIGIBILITY FOR CARE** (cont.)

c. Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

d. Eating: How person eats and drinks (regardless of skill);

e. Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, managed ostomy or catheter, adjusts clothes;

f. Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

g. Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

B. Level II: A member meets the eligibility requirements for Level II if the following are met:

1. At least "extensive assistance" (defined in 26.01) and a "one-person physical assist" (defined in 26.01) are needed for at least two of the following five activities of daily living listed in 26.02-2 (A) (2) above: bed mobility, transfer, locomotion, eating, toilet use.

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OR

2. Member meets two of the following three criteria:

a. Cognition Threshold:

i. Scores a 1 on Section C.1a of the MED form on short-term memory (recall after five minutes). A score of 1 indicates memory problems; and

ii. Can recall no more than two (2) of the following items from Section C.2 of MED form, Memory/Recall Ability: current season, location of own room, names/faces, where he/she is; and

iii. Scores a 2 or 3 under Section C.3 of MED form, Cognitive Skills for Daily Decision-Making. Moderately impaired (decisions poor; cues/supervision required) will be scored as 2 and severely impaired (never/rarely made decisions) will be scored as 3.

b. Behavior threshold: member must score a 2 or 3 under Section D.1 of the MED form, Problem Behavior. This behavior includes wandering, being verbally abusive, physically abusive, and/or demonstrating socially inappropriate behavior 4 or more days per week.

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c. At least "extensive assistance" (defined in 26.01) and a "one-person physical assist" (defined in 26.01) is needed for at least one of the following five activities of daily living listed in 26.02-2 (A) (2) above: bed mobility, transfer, locomotion, eating, toilet use.

C. Level III: A member must meet the medical eligibility requirements detailed in Section 67.02, Nursing Facility Services.

26.03 **DURATION OF CARE**

A member is eligible for as many MaineCare covered services as are specified in his or her individual plan of care. Beginning and end dates of a member's medical eligibility determination period correspond to the beginning and end dates for MaineCare coverage of the plan of care authorized by the provider or the Department.

26.04 **COVERED SERVICES**

Day Health. Day health services are those services provided outside the member's residence at a site licensed by the Bureau of Elder and Adult Services, on a regularly scheduled basis. The ongoing service may include, based on individual needs:

- monitoring of health care
- supervision, assistance with activities of daily living
- nursing
- rehabilitation
- health promotion activities
- exercise groups
- counseling

Noon meals and snacks are provided as a part of day health services.

26.05 **LIMITATIONS**

A. Members eligible for Level I of care may receive up to 16 hours per week of covered services under this Section.

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B. Members eligible for Level II of care may receive up to 24 hours per week of covered services under this Section.

26.05 **LIMITATIONS** (cont.)

Eff. 9-1-04 C. Members eligible for Level III of care may receive up to 40 hours per week of covered services under this Section.

26.06 NON-COVERED SERVICES

Refer to Chapter I, General Administrative Policies and Procedures for rules governing non-covered services in general. Day health services delivered to a member who is a resident in a private non-medical institution (PNMI) cannot be reimbursed under this rule.

26.07 POLICIES AND PROCEDURES

26.07-1 Professional Staff

Day health services are to be provided by the following staff in accordance with the individual written plan of care. Staff may be day health service employees or consultants to the service.

The following professional staff who are fully, provisionally or conditionally licensed or recognized to practice by the state or province in which services are provided, are qualified professional staff.

A. Registered Nurse
B. Practical Nurse
C. Social Worker
D. Occupational Therapist
E. Physical Therapist
F. Speech Language Pathologist
G. Other Qualified Staff may include CNAs and other service aides and assistants who provide day health services appropriate to their level of training under the supervision of a licensed professional who falls within the categories listed in subsections A through F, above. Supervision may be provided on a consulting basis.

26.07-2 Eligibility Determination

Applicants under this section must meet the eligibility requirements set forth in Section 26.02. An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the provider or the Department's authorized assessing agent.

Eff. 9-1-04 A. If financial eligibility for MaineCare has not been determined, the applicant, family member or guardian must be referred to the regional office of the Bureau of Family Independence, concurrent with the relevant medical eligibility determination process.

26.07 POLICIES AND PROCEDURES (cont.)

B. The Provider or Department's authorized assessing agent shall conduct a medical eligibility assessment using the Department's approved MED assessment form.

C. The provider must develop a plan of care.

D. The anticipated costs of services under this Section under the authorized plan of care must conform to the service limitations set forth in Section 26.05.

E. The provider must approve a classification period for the member, based upon the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor's clinical judgment. A classification period must not exceed twelve (12) months. Providers must send notice to the Department for each member classified that includes the start date for medical eligibility and the reassessment date.

Eff. 9-1-04

F. If the provider determines that the day health services are not medically necessary, then the provider must notify (using a notice format approved by the Department) the family in writing of which services will be provided and which services will not be provided, or provided only on a reduced basis. The notice must contain an understandable explanation of the reasons and inform the member of his or her appeal rights.

26.07-3 **Plan of Care**

A written plan of care must be established before services are provided. To be reimbursed, services must be consistent with the plan of care. At least one of the persons involved in developing the initial care plan must be a registered nurse or an LPN under the supervision of a registered nurse.

The written plan of care shall include, but is not necessarily limited to:

A. member's name, address, birth date

B. name of member's physician, if any

C. type of day health services needed

D. who shall deliver the service

E. frequency and expected duration of the services

F. long and short term goals

G. plans for coordinating with other health and social service agencies for

26.07 **POLICIES AND PROCEDURES** (cont.)

the delivery of services (see Medical Eligibility Determination (MED) form).

26.07-4 **Reclassification for Continued Services**

Eff. 9-1-04

Reassessment and prior authorization of services is required for all members in order for the reimbursement of services to continue uninterrupted beyond the approved classification period. The provider must conduct the reassessment within the timeframe of 14 days prior to and no later than the reclassification date. MaineCare coverage ends on the classification period end date unless a new classification period has been authorized.

At least one professional staff person, such as a nurse or social worker, shall be responsible for the development and monitoring of care plans. The care plan is to be reviewed and updated at least every six months or more often as necessary by a nurse or social worker.

The plan of care should be included as a subsection of a master plan of care if multidisciplinary services are provided to a member and are coordinated by a care manager.

26.07-5 **Member Records**

There must be a specific record for each member, which must include, but not necessarily be limited to:

A. member's name, address, sex, age, next-of-kin;

B. the Department’s approved medical eligibility assessment form;.

C. medical information, including:

1. statement of significant medical problems

2. written physician orders of current medications and treatments to be delivered at the day health setting

3. statement of limitations, if any, on the member’s participation in service activities

4. recommendations for therapies;

D. list of medications, prescribed and otherwise;

E. written plan of care;

F. summary notes for each date of service billed which include:

26.07 **POLICIES AND PROCEDURES** (cont.)

1. identification of the service provided, the date and provider;

2. signature of service provider;

3. date and full description of any unusual condition or unexpected event; and

G. monthly progress notes reflecting the progress that the member has made in relation to the plan of care. The licensed professional responsible for monitoring the plan of care must sign the progress notes, in conformance with licensing requirements.

26.07-6 **Member Appeals**

A member has the right to appeal in writing or orally any decision made by the Department or the day health service provider, to reduce, deny or terminate services provided under this benefit. In order for services to continue during the appeal process, a request must be received by the Department within ten (10) days of the notice to reduce or terminate services. Otherwise, an individual has sixty (60) days in which to appeal a decision. Members shall be informed of their right to request an Administrative Hearing in accordance with this Section and Chapter I of this manual.

Eff. 9-1-04

An appeal for members must be requested in writing or orally to:

Director
Bureau of Elder and Adult Services
c/o Hearings
11 State House Station
Augusta, ME 04333-0011

26.07-7 **Surveillance and Utilization Review**

All providers are subject to the Department's Surveillance and Utilization Review activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

26.08 **REIMBURSEMENT**

Reimbursement for covered services shall be the lower of:

A. The provider's usual and customary charge; or

B. The amount listed in the "Allowances for Day Health Service", Chapter III.

26.08 **REIMBURSEMENT** (cont.)

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment prior to billing MaineCare.

Reimbursement for services provided by licensed professionals listed in Section 26.06-1 on a consulting basis is included in the day health service reimbursement rate. The consulting provider must not bill separately for these services except for physical therapy, occupational therapy services, and speech therapy that are provided on an individual basis, rather than in a group, according to physician orders and a plan of care. These services may be billed in accordance with Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; or Section 110, Speech-Language Pathology Services, of the MaineCare Benefits Manual.

Eff. 9-1-04

Day health services provided to members of the Department’s Home and Community Benefits for the Elderly and for Adults with Disabilities must be reimbursed under the relevant rule, and not under this section.

26.09 **BILLING INSTRUCTIONS**

Providers must bill in accordance with the Department's Billing Instructions.

	PROC. CODE	DESCRIPTION	MAXIMUM ALLOWANCE	REMARKS
Eff.	S5100	Day Care Services – Level I- Adult – per ¼ hour	$2.36	Per 15 mins
9-1-04	S5100TF	Day Care Services-Level II- Adult- per ¼ hour	$2.36	Per 15 mins
	S5100TG	Day Care Services-Level III- Adult- per ¼ hour	$2.36	Per 15 mins